Agency 129

Kansas Department of Health and Environment—Division of Health Care Finance

Editor's Note:
Pursuant to Executive Reorganization Order (ERO) No. 38, the Kansas Health Policy Authority was abolished on July 1, 2011. Powers, duties and functions were transferred to the Kansas Department of Health and Environment (KDHE), Division of Health Care Finance. See L. 2012, Ch. 102.

Editor's Note:
K.S.A. 2005 Supp. 75-7401 thru 75-7405 and Section 42 of Chapter 187, 2005 Session Laws of Kansas transferred specific powers, duties, and regulatory authority of the Division of Health Policy and Finance (DHPF) within the Department of Administration to the Kansas Health Policy Authority (KHPA), effective July 1, 2006. The statutes provide that KHPA will be the single state agency for Medicaid, Medikan and Health Wave in Kansas.

Editor's Note:
The Division of Health Policy and Finance was established by 2005 Senate Bill 272. K.S.A. 2005 Supp. 75-7413 transferred specific powers, duties, and regulatory authority of the Secretary of Social and Rehabilitation Services on an interim basis to a new Division of Health Policy and Finance (DHPF) within the Department of Administration, created under K.S.A. 2005 Supp. 75-7406, effective July 1, 2005. The statute provides that DHPF will be the single state agency for Medicaid, Medikan and HealthWave in Kansas. The statute also establishes the Kansas Health Policy Authority (HPA) which will eventually assume these programs as well as other medical programs for the State of Kansas.

Articles

Article 5.—PROVIDER PARTICIPATION, SCOPE OF SERVICES, AND REIMBURSEMENTS FOR THE MEDICAID (MEDICAL ASSISTANCE) PROGRAM

129-5-1. Prior authorization. (a) Any medical service may be placed by the Kansas department of health and environment, division of health care finance on the published list of services requiring prior authorization or precertification for any of the following reasons:

(1) To ensure that provision of the service is medically necessary;

(2) to ensure that services that could be subject to overuse are monitored for appropriateness in each case; and

(3) to ensure that services are delivered in a cost-effective manner.

(b) Administration of covered pharmaceuticals in the following classes shall require prior authorization. A cross-reference of generic and brand names shall be made available upon request:

(1) Ace inhibitors:
(A) Quinapril;
(B) moexipril;
(C) perindopril;
(D) ramipril; and
(E) trandolopril;
(2) retinoids:
(A) Tretinoin;
(B) alitretinoin; and
(C) bexarotene;
(3) adjunct antiepileptic drugs:
(A) Gabitril;
(B) zonegran;
(C) clobazam;
(D) lacosamide; and
(E) rufinamide;
(4) angiotensin II receptor antagonists:

(A) Candesartan:
(B) candesartan-HCTZ;
(C) eprosartan;
(D) eprosartan-HCTZ;
(E) olmesartan;
(F) olmesartan-HCTZ; and
(G) azilsartan;
(5) antibiotics: telithromycin;
(6) anticholinergic urinary incontinence drugs:
(A) Flavoxate;
(B) oxybutynin XL;
(C) oxybutynin patches;
(D) trospium chloride;
(E) darifenacin; and
(F) oxybutynin, topical;
(7) antiemetics: nabilone;
(8) antipsoriatics:
(A) Alefacept; and
(B) ustekinumab;
(9) antiretroviral drugs:
(A) Enfuvirtide; and
(B) maraviroc;
(10) antirheumatics:
(A) Leflunomide;
(B) infliximab;
(C) anakinra;
(D) adalimumab;
(E) etonercept;
(F) abatacept;
(G) rituximab;
(H) golimumab;
(I) certolizumab; and
(J) tocilizumab;
(11) cervical dystonias:
(A) Onabotulinum toxin A;
(B) abobotulinum toxin A; and
(C) rimabotulinum toxin B;
(12) drugs for the treatment of osteoporosis: teriparatide;
(13) antituberculosis products:
(A) Aminosalicylate sodium;
(B) capreomycin;
(C) ethambutol;
(D) ethionamide;
(E) isoniazid;
(F) pyrazinamide; and
(G) rifampin and rifampin-isoniazid combinations;
(14) all decubitus and wound care products;
(15) all intravenous and oral dietary and nutritional products, including the following:
(A) Amino acids, injectable;
(B) 1-cysteine;
(C) lipids, injectable; and
(D) sodium phenylbutyrate;
(16) beta-blockers:
(A) Betaxolol;
(B) bisoprolol;
(C) carteolol;
(D) penbutolol;
(E) propranolol XL; and
(F) nebivolol;
(17) short-acting, inhaled beta 2 agonists:
(A) Metaproterenol inhaler;
(B) levalbuterol solution;
(C) albuterol solutions: 0.021% and 0.042%;
(D) levalbuterol inhaler; and
(E) pirbuterol inhaler;
(18) calcium channel blockers:
(A) Diltiazem extended release, with the following brand names:
(i) Cardizen SR®;
(ii) Cardizem CD®;
(iii) Cartia XT®;
(iv) Dilacor XR®;
(v) Taztia XT®; and
(vi) Cardizem LA®;
(B) verapamil sustained release, with the following brand names:
(i) Covera HS®; and
(ii) Verelan PM®;
(C) nifedipine sustained release, with the following brand names:
(i) Nifedical XL®; and
(ii) Procardia XL® and all generic equivalents;
(D) nisoldipine;
(E) felodipine;
(F) isradipine;
(G) nicardipine SR; and
(H) nifedipine immediate release, with the following brand names:
(i) Adalat® and all generic equivalents; and
(ii) Procardia® and all generic equivalents;
(19) fibric acid derivatives:
(A) Antara®; and
(B) Lofibra®;
(20) all growth hormones and growth hormone stimulating factor, including the following:
(A) Somatrem;
(B) somatropin;
(C) sermorelin; and
(D) mecasermin rinfabate;
(21) intranasal corticosteroids:
(A) Flunisolide;

(B) beclomethasone; and
(C) ciclesonide;
(22) inhaled corticosteroids:
(A) Flunisolide-menthol;
(B) flunisolide; and
(C) budesonide inhaled suspension;
(23) proton pump inhibitors:
(A) Esomeprazole;
(B) omeprazole;
(C) omeprazole OTC;
(D) lansoprazole;
(E) pantoprazole;
(F) rabeprazole;
(G) omeprazole $NaHCO_3$; and
(H) dexlansoprazole;
(24) monoclonal antibody for respiratory syncitial virus (RSV), including palivizumab;
(25) muscle relaxants:
(A) Tizanidine;
(B) orphenadrine;
(C) carisoprodol;
(D) carisoprodol-aspirin;
(E) carisoprodol-aspirin-caffeine;
(F) cyclobenzaprine;
(G) metaxolone;
(H) dantrolene; and
(I) orphenadrine-aspirin-caffeine;
(26) narcotics:
(A) Buprenorphine-naloxone; and
(B) buprenorphine;
(27) nonsteroidal, anti-inflammatory drugs:
(A) nabumetone;
(B) diclofenac patches;
(C) diclofenac, topical; and
(D) ketorolac, intranasal;
(28) drugs for the treatment of obesity:
(A) Orlistat; and
(B) phentermine;
(29) oxazolidinones, including linezolid;
(30) HMG-CoA reductase inhibitors:
(A) Pravastatin;
(B) fluvastatin;
(C) lovastatin; and
(D) pitavastatin;
(31) nonsedating antihistamines:
(A) Desloratidine;
(B) fexofenadine; and
(C) levocetirizine;
(32) H_2 antagonists: nizatidine;
(33) triptans:
(A) Zolmitriptan;
(B) frovatriptan;
(C) almotriptan;
(D) Alsuma™; and
(E) Sumavel®;
(34) antidiabetic drugs:
(A) Glipizide XL;
(B) glipizide-metformin;
(C) repaglinide;
(D) acarbose;
(E) Glucophage XR®;
(F) Fortamet®;
(G) Glumetza®;
(H) exenatide;
(I) pramlintide acetate; and
(J) liraglutide;
(35) the following types of syringes, penfills, and cartridges of insulin:
(A) Humalog®;
(B) Humalog Mix®;
(C) Humulin R®;
(D) Humulin N®;
(E) Humulin 70/30®;
(F) Novolog®;
(G) Novolog Mix®;
(H) Novolin R®;
(I) Novolin N®;
(J) Novolin 70/30®;
(K) Velosulin BR®; and
(L) insulin determir;
(36) hypnotics:
(A) Zaleplon;
(B) zolpidem;
(C) zolpidem CR; and
(D) eszopiclone;
(37) serotonin 5-HT_3 receptor antagonist antiemetics:
(A) Granisetron;
(B) dolasetron; and
(C) ondansetron film;
(38) influenza vaccines: Flumist®;
(39) monoclonal antibody for asthma: omalizumab;
(40) bisphosphonates:
(A) Risedronate; and
(B) risedronate-calcium;
(41) combination products for hypertension:
(A) Enalapriol maleate-felodipine;
(B) trandolapril-verapamil; and
(C) telmisartan-amlodipine;
(42) ophthalmic prostaglandin analogues:
(A) Bimatoprost; and
(B) unoprostone;
(43) topical immunomodulators:
(A) Protpic® (topical formulation); and
(B) Elidel®;

(44) narcotic analgesics: any transmucosal form of fentanyl;

(45) tramadol and all opioids, opioid combinations, and skeletal muscle relaxants, at any dose greater than the maximum recommended dose in a 31-day period;

(46) progestin for preterm labor: Makena®;

(47) aromatase inhibitors:

(A) Letrozole;

(B) anastrozole; and

(C) exemestane;

(48) long-acting, inhaled beta 2 agonists:

(A) Salmeterol;

(B) formoterol;

(C) arformoterol; and

(D) indacaterol;

(49) miscellaneous biologic agents;

(A) Canakinumab;

(B) natalizumab;

(C) denosumab; and

(D) rilonacept;

(50) stem cell mobilizers: plerixafor;

(51) antidotes: methylnaltrexone;

(52) hereditary angioedema agents:

(A) C1 esterase inhibitor;

(B) ecallantide; and

(C) icatibant;

(53) anti-hepatitis C virus agents:

(A) Boceprevir; and

(B) telaprevir;

(54) cystic fibrosis agents: ivacaftor;

(55) agents for gout:

(A) Febuxostat; and

(B) pegloticase;

(56) phenylketonurics: sapropterin;

(57) topical anesthetics: lidocaine;

(58) antithrombin agents: eltrombopag;

(59) anti-malarials: quinine;

(60) hormone analog for precocious puberty: histrelin acetate;

(61) agents for chorea associated with Huntington's disease: tetrabenazine;

(62) enzyme preparations: collegenase clostridium histolyticum; and

(63) agents for cataplexy: sodium oxybate.

(c) Failure to obtain prior authorization, if required, shall negate reimbursement for the service and any other service resulting from the unauthorized or noncertified treatment. The prior authorization shall affect reimbursement to all providers associated with the service.

(d) The only exceptions to prior authorization shall be the following:

(1) Emergencies. If certain surgeries and procedures that require prior authorization are performed in an emergency situation, the request for authorization shall be made within two working days after the service is provided.

(2) Situations in which services requiring prior authorization are provided and retroactive eligibility is later established. When an emergency occurs or when retroactive eligibility is established, prior authorization for that service shall be waived, and if medical necessity is documented, payment shall be made.

(e) Services requiring prior authorization shall be considered covered services within the scope of the program, unless the request for prior authorization is denied. (Authorized by K.S.A. 2011 Supp. 39-7,120, as amended by L. 2012, ch. 102, sec. 9, K.S.A. 2011 Supp. 65-1,254, K.S.A. 2011 Supp. 75-7412, as amended by L. 2012, ch. 102, sec. 43; implementing K.S.A. 2011 Supp. 39-7,120, as amended by L. 2012, ch. 102, sec. 9, and K.S.A. 2011 Supp. 39-7,121a, as amended by L. 2012, ch. 102, sec. 11; effective Oct. 28, 2005; amended June 2, 2006; amended Aug. 11, 2006; amended Nov. 17, 2006; amended March 16, 2007; amended Oct. 19, 2007; amended May 23, 2008; amended Feb. 17, 2012; amended Oct. 19, 2012.)

129-5-78. Scope of and reimbursement for home- and community-based services for persons with traumatic brain injury. (a) The scope of allowable home- and community-based services (HCBS) for persons with traumatic brain injury shall consist of those services authorized by the applicable federally approved waiver to the Kansas medicaid state plan. Recipients of services provided pursuant to this waiver shall be required to show the capacity to make progress in their rehabilitation and independent living skills.

(b) The need for HCBS shall be determined by an individualized assessment of the prospective recipient by a provider enrolled in the program. HCBS shall be provided only in accordance with a plan of care written by a case manager.

(c) HCBS, which shall require prior authorization by the Kansas medicaid HCBS program manager, may include one or more of the following:

(1) Rehabilitation therapies, which may consist of any of the following:

(A) Occupational therapy;

(B) physical therapy;

(C) speech-language therapy;

(D) cognitive rehabilitation; or

(E) behavioral therapy;

(2) personal services;

(3) medical equipment, supplies, and home modification not otherwise covered under the Kansas medicaid state plan;

(4) sleep-cycle support services;

(5) a personal emergency response system and its installation; or

(6) provision of or education on transitional living skills.

(d) Case management services up to a maximum of 160 hours each calendar year, which may be exceeded only with prior authorization by the Kansas medicaid HCBS program manager, shall be provided to all HCBS recipients under the traumatic brain injury program.

(e) The fee allowed for home- and community-based services for persons with traumatic brain injury shall be the provider's usual and customary charges, except that no fee shall be paid in excess of the waiver's range maximum. (Authorized by K.S.A. 2008 Supp. 75-7403 and 75-7412; implementing K.S.A. 2008 Supp. 75-7405 and 75-7408; effective July 18, 2008; amended Oct. 16, 2009.)

129-5-118. Scope of federally qualified health center services. For purposes of this regulation, a federally qualified health center shall mean a community health center, federally qualified health center (FQHC) look-alike, or an urban Indian organization receiving funds under the Indian health care improvement act that is accepted by the centers for medicare and medicaid to furnish federally qualified health center services for participation under medicare and medicaid. An FQHC look-alike shall mean an organization that meets all of the eligibility requirements of an organization that receives a public health service (PHS) section 330 grant but does not receive grant funding. (a) The services provided by the following health care professionals shall be billable as federally qualified health center services:

(1) Physician and physician assistant pursuant to K.A.R. 129-5-88;

(2) advanced registered nurse practitioner pursuant to K.A.R. 30-5-113;

(3) dentist and dental hygienist pursuant to K.A.R. 30-5-100;

(4) licensed mental health practitioner pursuant to K.A.R. 30-5-104;

(5) clinical social worker pursuant to K.A.R. 30-5-86;

(6) visiting nurse pursuant to K.A.R. 30-5-89; and

(7) for kan be healthy nursing assessments only, registered nurse pursuant to K.A.R. 30-5-87.

(b) Covered services of federally qualified health centers shall include the following:

(1) The services and supplies furnished as an incident to the professional services provided by the health care professionals specified in subsection (a); and

(2) other ambulatory services covered under the medicaid state plan, if provided by the federally qualified health center.

(c) (1) Preventive primary services shall be furnished by or under the direct supervision of any of the following:

(A) Physician;

(B) nurse practitioner;

(C) physician assistant;

(D) nurse midwife;

(E) licensed mental health practitioner;

(F) clinical social worker; or

(G) either a member of the center's health care staff who is an employee of the center or a physician under arrangements with the center.

(2) Preventive primary services shall include only drugs and biologicals that cannot be self-administered, unless §1861(s) of the social security act provides for coverage of the drug regardless of whether the drug is self-administered.

(d) The following preventive primary services may be covered when provided by federally qualified health centers to medicaid beneficiaries:

(1) Medical social services;

(2) nutritional assessment and referral;

(3) preventive health education;

(4) children's eye and ear examinations;

(5) prenatal and postpartum care;

(6) prenatal services;

(7) well child care, including periodic screening;

(8) providing immunizations, including tetanus-diphtheria booster and influenza vaccine;

(9) voluntary family planning services;

(10) taking patient history;

(11) blood pressure measurement;

(12) weight measurement;

(13) physical examination targeted to risk;

(14) visual acuity screening;

(15) hearing screening;

(16) cholesterol screening;

(17) stool testing for occult blood;

(18) dipstick urinalysis;

(19) risk assessment and initial counseling regarding risks; and

(20) the following services, for women only:

(A) Clinical breast exam;

(B) referral for mammography; and

(C) thyroid function test.

(3) Preventive primary services shall not include group or mass information programs, health education classes, and group education activities, which may include media productions and publication and services for eyeglasses and hearing aids.

(e) "Visiting nurse" shall include a registered nurse or licensed practical nurse who provides part-time or intermittent nursing care to a patient at the beneficiary's place of residence under a written plan of treatment prepared by a physician. The place of residence shall not include a hospital or long-term care facility. This nursing care shall be covered only if there is no home health agency in the area.

(f) Federally qualified health center services provided at a location other than a federally qualified health center shall meet the following conditions:

(1) No services are provided at an inpatient hospital, outpatient hospital, or hospital emergency room.

(2) The services provided are listed in subsection (b).

(3) The services are provided to a patient of a federally qualified health center.

(4) The health professional providing the services is an employee of a federally qualified health center or under contract with a federally qualified health center and is required to seek compensation for that person's services from the federally qualified health center. (Authorized by K.S.A. 2008 Supp. 75-7403 and 75-7412; implementing K.S.A. 2008 Supp. 75-7405 and 75-7408; effective June 2, 2006; amended March 19, 2010.)

129-5-118a. Reimbursement for federally qualified health center services. Reimbursement shall not exceed the reasonable cost of federally qualified health center services and other ambulatory services covered under the Kansas medical assistance program. "Reasonable cost" shall consist of the necessary and proper cost incurred by the provider in furnishing covered services to program beneficiaries, subject to the cost principles and limits specified in K.A.R. 129-5-118a (c)(1) and K.A.R. 129-5-118b. (a) Reimbursement method. An interim per visit rate shall be paid to each federally qualified health center provider, with a retroactive cost settlement for each facility fiscal year.

(1) Interim reimbursement rate. The source and the method of determination of interim rate shall depend on whether the federally qualified health center is a new enrollee of the Kansas medical assistance program or is a previously enrolled provider. Under special circumstances, the interim rate may be negotiated between the agency and the provider.

(A) Newly enrolled facility. If the facility is an already-established federally qualified health center with an available medicare cost report, an all-inclusive rate derived from the cost report may be used for setting the initial medicaid interim payment rate. If the facility is an already-established federally qualified health center opening a new service location, then the rate from the already-established federally qualified health center shall be used for the new service location. If the facility converted from a rural health clinic to a federally qualified health center, then the rate from the rural health clinic shall be used for the new federally qualified health center. For all other circumstances, the initial payment rate shall be based on the average of the current reimbursement rates for previously enrolled federally qualified health center providers.

(B) Previously enrolled facility. After the facility submits a federally qualified health center cost report, the agency shall determine the maximum allowable medicaid rate per visit as specified in subsection (c). If a significant change of scope of services or a significant capital project has been implemented, the federally qualified health center shall submit an interim cost report if the center wants a change to the existing rate. The agency and the federally qualified health center shall use the interim cost report to negotiate a new interim rate.

(2) Visit. A "visit" shall mean face-to-face encounter between a center patient and a center health care professional as defined in K.A.R. 129-5-118. Encounters with more than one health professional or multiple encounters with the same health professional that take place on the same day shall constitute a single visit, except under either of the following circumstances:

(A) The patient suffers an illness or injury re-

quiring additional diagnosis or treatment after the first encounter.

(B) The patient has a different type of visit on the same day, which may consist of a dental, medical, or mental health visit.

(3) Retroactive cost settlement. For each reporting period, the agency shall compare the total maximum allowable medicaid cost with the total payments to determine the program overpayment or underpayment. Total payments shall include interim payments, third-party liability, and any other payments for covered federally qualified health center services. The cost report and supplemental data submitted by the provider, the medicare cost report, and the medicaid-paid claims data obtained from the program's fiscal agent shall be used for these calculations.

(b) Cost reporting. Each federally qualified health center shall submit a completed cost report. The form used for cost reporting shall be the most current version of the medicare financial and statistical report form for independent rural health clinics and freestanding federally qualified health centers with adjustments made, as necessary, to report the cost and number of visits for medicaid-covered services pursuant to K.A.R. 129-5-118.

(1) Filing requirements. Each provider shall be required to file annual cost reports on a fiscal year basis.

(A) Cost reports shall be received no later than five months after the end of the facility's fiscal year. An extension in due date may be granted by the agency upon request, if necessary due to circumstances beyond the control of the federally qualified health center.

(B) Each provider filing a cost report after the due date without a preapproved extension shall be subject to the following penalties:

(i) If the cost report has not been received by the agency by the close of business on the due date, all further payments to the provider may be withheld and suspended until the complete financial and statistical report has been received.

(ii) Failure to submit the completed financial and statistical report within one year after the end of the cost report period may be cause for termination from the Kansas medical assistance program.

(2) Fiscal and statistical data. The preparation of the cost report shall be based upon the financial and statistical records of the facility and shall use the accrual basis of accounting. The reported data shall be accurate and adequately supported to facilitate verification and analysis for the determination of allowable costs.

(3) Supplemental data. The following additional information shall be submitted to support reported data and to facilitate cost report review, verifications, and other analysis.

(A) A working trial balance. This balance shall contain account numbers, descriptions of the accounts, the amount of each account, the cost report expense line on which the account was reported, and fiscal year-end adjusting entries to facilitate reconciliation between the working trial balance and the cost report. The facility shall bear the burden of proof that the reported data accurately represents the cost and revenue as recorded in the accounting records. All unexplained differences shall be used to reduce the allowable cost.

(B) Financial statements and management letter. These documents shall be prepared by the facility's independent auditors and shall reconcile with the cost report.

(C) Depreciation schedule. This schedule shall support the depreciation expense reported on the cost report.

(D) Other data. Data deemed necessary by the agency for verification and rate determination shall also be submitted.

(c) Determination of reimbursable medicaid rate per visit.

(1) Allowable facility costs. This term shall mean costs derived from reported expenses after making adjustments resulting from cost report review and application of the cost reimbursement principles specified in K.A.R. 129-5-118b.

(2) Allocation of overhead costs.

(A) Total allowable administrative and facility costs shall be distributed to the following cost centers:

(i) Federally qualified health center costs;

(ii) non-federally qualified health center costs; and

(iii) nonreimbursable costs, excluding bad debt.

(B) Accumulated direct cost in each cost center shall be used as the basis for the overhead cost allocation.

(3) Average allowable cost per visit. The total allowable facility costs shall be divided by the total number of visits.

(4) Reimbursable medicaid rate. The reimbursable medicaid rate per visit shall not be more than 100 percent of the reasonable and related cost of

furnishing federally qualified health center services covered in K.A.R. 129-5-118b.

(d) Fiscal and statistical records and audits.

(1) Recordkeeping. Each provider shall maintain sufficient financial records and statistical data for accurate determination of reasonable costs. Standardized definitions and reporting practices widely accepted among federally qualified health centers and related fields shall be followed, except to the extent that these definitions and practices may conflict with or be superseded by state or federal medicaid requirements.

(2) Audits and reviews.

(A) Each provider shall furnish any information to the agency that may be necessary to meet the following criteria:

(i) Ensure proper payment by the program pursuant to this regulation and K.A.R. 129-5-118b; and

(ii) substantiate claims for program payments.

(B) Each provider shall permit the agency to examine any records and documents necessary to ascertain information for determination of the accurate amount of program payments. These records shall include the following:

(i) Matters of the facility ownership, organization, and operation;

(ii) fiscal, statistical, medical, and other recordkeeping systems;

(iii) federal and state income tax returns and all supporting documents;

(iv) documentation of asset acquisition, lease, sale, or other transaction;

(v) management arrangements;

(vi) matters pertaining to the cost of operation; and

(vii) health center financial statements.

(C) Other records and documents shall be made available to the agency as requested.

(D) All records and documents shall be available in Kansas.

(E) Each provider shall furnish to the agency, upon request, copies of patient service charge schedules and any subsequent changes to these schedules.

(F) The agency shall suspend program payments if it is determined that a provider does not maintain adequate records for the determination of reasonable and adequate rates under the program or if the provider fails to furnish requested records and documents to the agency.

(G) Thirty days before suspending payment to the provider, written notice shall be sent by the agency to the provider of the agency's intent to suspend payment. The notice shall explain the basis for the agency's determination and identify the provider's recordkeeping deficiencies.

(H) All provider records that support reported costs, charges, revenue, and patient statistics shall be subject to audits by the agency, the United States department of health and human services, and the United States general accounting office. These records shall be retained for at least five years after the date of filing the cost report with the agency. (Authorized by K.S.A. 2008 Supp. 75-7403 and 75-7412; implementing K.S.A. 2008 Supp. 75-7405 and 75-7408; effective March 19, 2010.)

129-5-118b. Cost reimbursement principles for federally qualified health center services and other ambulatory services. The medicare cost reimbursement principles contained in subparts A and G in 42 C.F.R. part 413, as revised on October 1, 2009 and hereby adopted by reference, and the cost principles specified in this regulation and in K.A.R. 129-5-118a shall be applicable to the financial and statistical data reported by the federally qualified health center for the determination of reasonable cost of providing covered services. (a) Nonreimbursable costs. Each cost that is not related to patient care and is not necessary for the efficient delivery of covered federally qualified health center services and other ambulatory services shall be excluded from the medicaid rate determination. In addition, the following expenses shall be considered nonreimbursable:

(1) Salaries and fees paid to nonworking directors and officers;

(2) uncollectible debts;

(3) donations and contributions;

(4) fund-raising expenses;

(5) taxes including the following:

(A) Those from which the provider is entitled to obtain exemption;

(B) those on property not used in providing covered services; and

(C) those levied against a patient and remitted by the provider;

(6) life insurance premiums for directors, officers, and owners;

(7) the imputed value of in-kind services rendered by nonpaid workers and volunteers;

(8) the cost of social, fraternal, civic, and other

organizations associated with activities unrelated to patient care;

(9) all expenses related to vending machines;

(10) board of director costs;

(11) the cost of advertising for promoting the services offered by the facility to attract more patients;

(12) public relations and public information expenses;

(13) penalties, fines, and late charges, including interest paid on state and federal payroll taxes;

(14) the cost of items or services provided only to non-Kansas medical assistance program patients and reimbursed by third-party payers;

(15) all expenses associated with the ownership, lease, or charter of airplanes;

(16) bank overdraft charges and other penalties;

(17) the cost associated with group health education classes, activities, and mass information programs including media productions, brochures, and other publications;

(18) expense items without indication of their nature or purpose including "other" and "miscellaneous," without proper documentation when requested;

(19) non-arm's-length transactions;

(20) legal and other costs associated with litigation between a provider and state or federal agencies, unless litigation is decided in the provider's favor; and

(21) legal expenses not related to patient care.

(b) Costs allowed with limitations and conditions.

(1) Loan acquisition fees and standby fees. These fees shall be amortized over the life of the loan and shall be allowed only if the loan is related to patient care.

(2) Taxes associated with financing the operations. These taxes shall be allowed only as amortized cost.

(3) Special assessments on land for capital improvements. These assessments shall be amortized over the estimated useful life of the improvements and allowed only if related to patient care.

(4) Start-up costs of a new facility.

(A) Start-up costs may include the following:

(i) Staff salaries and consultation fees;

(ii) utilities;

(iii) taxes;

(iv) insurance;

(v) mortgage interest;

(vi) employee training; and

(vii) any other allowable cost incidental to the operation of the facility.

(B) A start-up cost shall be recognized only if it meets the following criteria:

(i) Is incurred before the opening of the facility;

(ii) is related to developing the facility's ability to provide covered services;

(iii) is amortized over a period of 60 months or more; and

(iv) is identified in the cost report as a start-up cost.

(5) Expenses. Each cost that can be identified as an organization expense or capitalized as a construction expense shall be appropriately classified and excluded from start-up costs.

(6) Payments made to related parties for services, facilities, and supplies. These payments shall be allowed at the lower of the actual cost to the related party and the market price.

(7) Premium payments. If a provider chooses to pay in excess of the market price for supplies or services, the agency shall use the market price to determine the allowable cost in the absence of a clear justification for the premium.

(8) Job-related training. The cost of this training shall be the actual amount minus any reimbursement or discount received by the provider.

(9) Lease payments. These payments shall be allowed only if reported in accordance with the generally accepted accounting principles appropriate to the reporting period.

(c) Interest expense. Only necessary and accurate interest on working capital indebtedness shall be an allowable cost.

(1) The interest expense shall be allowed only if it is established with either of the following:

(A) Any lender or lending organization not related to the borrower, or

(B) the central office and other related parties under the following conditions:

(i) The terms and conditions of payment of the loans are on arm's-length basis with a recognized lending institution;

(ii) the provider demonstrates, to the satisfaction of the agency, a primary business purpose for the loan other than increasing the rate of reimbursement; and

(iii) the transaction is recognized and reported by all parties for federal income tax purposes.

(2) Interest expense shall be reduced by investment income from both restricted and unrestricted idle funds and funded reserve accounts, except when the income is from restricted or un-

restricted gifts, grants, and endowments held in separate accounts with no commingling with other funds. Income from the provider's qualified pension fund shall not be used to reduce interest expense.

(3) Interest earned on restricted and unrestricted industrial revenue bond reserve accounts and sinking fund accounts shall be offset against interest expense up to and including the amount of the related interest expense.

(4) The interest expense on that portion of the facility acquisition loan attributable to an excess over historic cost or other cost basis recognized for program purposes shall not be considered a reasonable cost.

(d) Central office cost. This subsection shall be applicable in situations in which the federally qualified health center is one of several programs or departments administered by a central office or organization and the total administrative cost incurred by the central office is allocated to all components.

(1) Allocation of the central office cost shall use a logical and equitable basis and shall conform to generally accepted accounting procedures.

(2) The central office cost allocated to the federally qualified health center shall be allowed only if the amount is reasonable and if the central office provided a service normally available in similar facilities enrolled in the program.

(3) The provider shall bear the burden of furnishing sufficient evidence to establish the reasonability of the level of allocated cost and the nature of services provided by the central office.

(4) All costs incurred by the central office shall be allocated to all components as a central cost pool, and no portion of the central office cost shall be directed to individual facilities operated by the provider or reported on any line of the cost report other than the appropriate line of the central office cost on any other line of the cost report outside of the central office cost allocation plan.

(5) Only patient-related central office costs shall be recognized, which shall include the following:

(A) Cost of ownership or arm's-length rent or lease expense for office space;

(B) utilities, maintenance, housekeeping, property tax, insurance, and other facility costs;

(C) employee salaries and benefits;

(D) office supplies and printing;

(E) management consultant fees;

(F) telephone and other means of communication;

(G) travel and vehicle expenses;

(H) allowable advertising;

(I) licenses and dues;

(J) legal costs;

(K) accounting and data processing; and

(L) interest expense.

(6) The cost principles and limits specified in this regulation shall also apply to central office costs.

(7) Estimates of central office costs shall not be allowed.

(e) Revenue offsets. Revenue items shall be deducted from the appropriate expense item or cost center in accordance with this subsection.

(1) Revenue with insufficient explanation of its nature or purpose shall be offset against operating costs.

(2) Expense recoveries credited to expense accounts shall not be reclassified as revenue. (Authorized by K.S.A. 2008 Supp. 75-7403 and 75-7412; implementing K.S.A. 2008 Supp. 75-7405 and 75-7408; effective June 2, 2006; amended March 19, 2010.)

Article 10.—ADULT CARE HOME PROGRAM

129-10-31. Responsibilities of, assessment of, and disbursements for the nursing facility quality care assessment program. (a) In addition to the terms defined in K.S.A. 2013 Supp. 75-7435 and amendments thereto, the following terms shall have the meanings specified in this subsection, unless the context requires otherwise.

(1) "High medicaid volume skilled nursing care facility" means any facility that provided more than 25,000 days of nursing facility care to medicaid recipients during the most recent calendar year cost-reporting period.

(2) "Kansas homes and services for the aging," as used in K.S.A. 2013 Supp. 75-7435 and amendments thereto, means leadingage Kansas.

(3) "Nursing facility quality care assessment program" means the determination, imposition, assessment, collection, and management of an annual assessment imposed on each licensed bed in a skilled nursing care facility required by K.S.A. 2013 Supp. 75-7435, and amendments thereto.

(4) "Skilled nursing care facility that is part of

a continuing care retirement facility" means a provider who is certified as such by the Kansas insurance department before the start of the state's fiscal year in which the assessment process is occurring.

(5) "Small skilled nursing care facility" means any facility with fewer than 46 licensed nursing facility beds.

(b) The assessment shall be based on a state fiscal year. Each skilled nursing facility shall pay the annual assessment as follows:

(1) The assessment amount shall be $325 annually per licensed bed for the following:

(A) Each skilled nursing care facility that is part of a continuing care retirement facility;

(B) each small skilled nursing care facility; and

(C) each high medicaid volume skilled nursing care facility.

(2) The assessment amount for each skilled nursing care facility other than those identified in paragraphs (c)(1)(A) through (C) shall be $1,950 annually per licensed bed.

(3) The assessment amount shall be paid according to the method of payment designated by the secretary of the Kansas department of health and environment. Any skilled nursing care facility may be allowed by the secretary of the Kansas department of health and environment to have an extension to complete the payment of the assessment, but no such extension shall exceed 90 days. (Authorized by and implementing K.S.A. 2013 Supp. 75-7435; effective Feb. 18, 2011; amended Dec. 27, 2013.)